		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026716

Facility Name: Robings Manor Nursing Home

Address: 502 North Main Street (Number) Brighton (City) 62012 (Zip Code)

County: Macoupin

Telephone Number: (618) 372-3232 **Fax #** (618) 372-7117

IDPA ID Number: 371068286004

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
		X	"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,150	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,738	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,888	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,277	1,277	8
9	SNF/PED					9
10	ICF	18,274	4,419		22,693	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,274	4,419	1,277	23,970	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.31%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 1,277

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	73,383	9,677		83,060		83,060	5,470	88,530			1
2	Food Purchase		98,332		98,332		98,332	(3,418)	94,914			2
3	Housekeeping	68,920	8,236		77,156		77,156	22	77,178			3
4	Laundry	22,548	6,326		28,874		28,874	(801)	28,073			4
5	Heat and Other Utilities			65,200	65,200		65,200	474	65,674			5
6	Maintenance	19,413	33,201	846	53,460		53,460	1,341	54,801			6
7	Other (specify):* mgmt alloc of benefits							934	934			7
8	**TOTAL General Services**	184,264	155,772	66,046	406,082		406,082	4,022	410,104			8
	B. Health Care and Programs											
9	Medical Director			8,019	8,019		8,019		8,019			9
10	Nursing and Medical Records	649,666	50,533	525	700,724		700,724	11,467	712,191			10
10a	Therapy			125,448	125,448		125,448	4	125,452			10a
11	Activities	17,253	3,446		20,699		20,699	5	20,704			11
12	Social Services	35,118	691		35,809		35,809		35,809			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* mgmt alloc of benefits							1,108	1,108			15
16	**TOTAL Health Care and Programs**	702,037	54,670	133,992	890,699		890,699	12,584	903,283			16
	C. General Administration											
17	Administrative	60,674		184,821	245,495		245,495	(120,774)	124,721			17
18	Directors Fees											18
19	Professional Services			21,738	21,738		21,738	11,569	33,307			19
20	Dues, Fees, Subscriptions & Promotions			3,621	3,621		3,621	515	4,136			20
21	Clerical & General Office Expenses		3,537	10,821	14,358		14,358	39,574	53,932			21
22	Employee Benefits & Payroll Taxes			155,216	155,216		155,216		155,216			22
23	Inservice Training & Education			769	769		769	660	1,429			23
24	Travel and Seminar			370	370		370	1,401	1,771			24
25	Other Admin. Staff Transportation			4,114	4,114		4,114	2,693	6,807			25
26	Insurance-Prop.Liab.Malpractice			46,310	46,310		46,310	942	47,252			26
27	Other (specify):* mgmt alloc of benefits							10,864	10,864			27
28	**TOTAL General Administration**	60,674	3,537	427,780	491,991		491,991	(52,556)	439,435			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	946,975	213,979	627,818	1,788,772		1,788,772	(35,950)	1,752,822			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Robings Manor Nursing Home #0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			24,912	24,912		24,912	8,191	33,103			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			112,224	112,224		112,224	5,329	117,553			32
33	Real Estate Taxes			11,445	11,445		11,445	346	11,791			33
34	Rent-Facility & Grounds							2,702	2,702			34
35	Rent-Equipment & Vehicles			2,349	2,349		2,349	644	2,993			35
36	Other (specify):*											36
37	**TOTAL Ownership**			150,930	150,930		150,930	17,212	168,142			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,617		17,617		17,617		17,617			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,332	37,332		37,332		37,332			42
43	Other (specify):* Nonallowable Costs			10,103	10,103		10,103	(10,103)				43
44	**TOTAL Special Cost Centers**		17,617	47,435	65,052		65,052	(10,103)	54,949			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	946,975	231,596	826,183	2,004,754		2,004,754	(28,841)	1,975,913			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,420)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,427)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,525	30		9
10	Interest and Other Investment Income	(3)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(994)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(657)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,832)	43		24
25	Fund Raising, Advertising and Promotional	(1,979)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Sch5A	(3,134)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,921)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(16,920)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (16,920)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,841)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider #: 0026716
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
To offset maintenance & repair	(1920)	6
To offset vending expense	(146)	43
To disaloow X-Ray expenes	(347)	39
To disallow Lab expense	(721)	39
	(3,134)	

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home

ID# 0026716

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Robings Manor Nursing Home # 0026716 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	5,219	0	0	0	0	0	0	0	0	0	5,219	1
2	Food Purchase	(3,420)	2	0	0	0	0	0	0	0	0	0	(3,418)	2
3	Housekeeping	0	22	0	0	0	0	0	0	0	0	0	22	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	474	0	0	0	0	0	0	0	0	0	474	5
6	Maintenance	0	3,261	0	0	0	0	0	0	0	0	0	3,261	6
7	Other (specify):*	0	934	0	0	0	0	0	0	0	0	0	934	7
8	**TOTAL General Services**	(3,420)	9,912	0	0	0	0	0	0	0	0	0	6,492	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	11,467	0	0	0	0	0	0	0	0	0	11,467	10
10a	Therapy	0	4	0	0	0	0	0	0	0	0	0	4	10a
11	Activities	0	5	0	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,108	0	0	0	0	0	0	0	0	0	1,108	15
16	**TOTAL Health Care and Programs**	0	12,584	0	0	0	0	0	0	0	0	0	12,584	16
	C. General Administration													
17	Administrative	0	(120,774)	0	0	0	0	0	0	0	0	0	(120,774)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,569	0	0	0	0	0	0	0	0	0	11,569	19
20	Fees, Subscriptions & Promotions	0	515	0	0	0	0	0	0	0	0	0	515	20
21	Clerical & General Office Expenses	0	0	39,574	0	0	0	0	0	0	0	0	39,574	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	660	0	0	0	0	0	0	0	0	660	23
24	Travel and Seminar	0	0	1,401	0	0	0	0	0	0	0	0	1,401	24
25	Other Admin. Staff Transportation	0	0	2,693	0	0	0	0	0	0	0	0	2,693	25
26	Insurance-Prop.Liab.Malpractice	0	0	942	0	0	0	0	0	0	0	0	942	26
27	Other (specify):*	0	0	10,864	0	0	0	0	0	0	0	0	10,864	27
28	**TOTAL General Administration**	0	(108,690)	56,134	0	0	0	0	0	0	0	0	(52,556)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,420)	(86,194)	56,134	0	0	0	0	0	0	0	0	(33,480)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Robings Manor Nursing Home # 0026716 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,525	0	4,666	0	0	0	0	0	0	0	0	8,191	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3)	0	5,332	0	0	0	0	0	0	0	0	5,329	32
33	Real Estate Taxes	0	0	346	0	0	0	0	0	0	0	0	346	33
34	Rent-Facility & Grounds	0	0	2,702	0	0	0	0	0	0	0	0	2,702	34
35	Rent-Equipment & Vehicles	0	0	94	0	0	0	0	0	0	0	0	94	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,522	0	13,140	0	0	0	0	0	0	0	0	16,662	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,889)	0	0	0	0	0	0	0	0	0	0	(8,889)	43
44	**TOTAL Special Cost Centers**	(8,889)	0	0	0	0	0	0	0	0	0	0	(8,889)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,787)	(86,194)	69,274	0	0	0	0	0	0	0	0	(25,707)	45

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See atttached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 5,219	$ 5,219	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	2	2	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	474	474	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,261	3,261	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	934	934	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	11,467	11,467	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	4	4	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	5	5	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,108	1,108	10
11	V	17	Administrative	184,821	Petersen Health Care, Inc.	100.00%	64,047	(120,774)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	11,569	11,569	12
13	V	20	Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	515	515	13
14	Total			$ 184,821			$ 98,627	$ * (86,194)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 39,574	$ 39,574	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	660	660	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,401	1,401	17
18	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,693	2,693	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	942	942	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,864	10,864	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,666	4,666	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,332	5,332	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	346	346	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	2,702	2,702	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	94	94	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 69,274	$ * 69,274	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor
Provider #0026716
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City	
In-State:		
Arcola Health Care Center	Arcola, IL	
Bement Health Care Center	Bement, IL	
Casey Health Care Center	Casey, IL	
Countryview Terrace	Louisville, IL	
Eastview Terrace	Sullivan, IL	
El Paso Health Care Center	El Paso, IL	
Flora Health Care Center	Flora, IL	
Havana Health Care Center	Havana, IL	
Kewanee Care Home	Kewanee, IL	
Palm Terrace of Mattoon	Mattoon, IL	
Prairie Rose Health Care Center	Pana, IL	
Robings Manor Nursing Home	Brighton, IL	
Royal Oaks Care Center	Kewanee, IL	
Sheldon Health Care Center	Sheldon, IL	
Sullivan Health Care Center	Sullivan, IL	
Sunset Manor Nursing Home	Canton, IL	
Tuscola Health Care Center	Tuscola, IL	
Out-of-State:		
Meadow Lawn Nursing Center	Davenport, IA	
Related Assisted Living		
Kewanee Courtyard Estates	Kewanee, IL	
Kewanee Courtyard Village	Kewanee, IL	
Monmouth Courtyard Estates	Monmouth, IL	
Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	1,028,942	3	6.00	Salary	$ 64,047	L17,C8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 64,047		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Robings Manor
Provider #0026716
12/31/2004

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	$ 89,079	$ 89,071	23,970	$ 5,219	1
2	2	Food	Patient Days	409,056	18	33		23,970	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		23,970	22	3
4	5	Utilities	Patient Days	409,056	18	8,082		23,970	474	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	23,970	3,261	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		23,970	934	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	23,970	11,467	7
8	10A	Therapy	Patient Days	409,056	18	75		23,970	4	8
9	11	Activities	Patient Days	409,056	18	86		23,970	5	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		23,970	1,108	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	23,970	64,047	11
12	19	Professional Services	Patient Days	409,056	18	197,418		23,970	11,569	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		23,970	515	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	23,970	39,574	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		23,970	660	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		23,970	1,401	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		23,970	2,693	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		23,970	942	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		23,970	10,864	19
20	30	Depreciation	Patient Days	409,056	18	79,620		23,970	4,666	20
21	32	Interest	Patient Days	409,056	18	90,987		23,970	5,332	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		23,970	346	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		23,970	2,702	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		23,970	94	24
25	TOTALS					$ 2,865,264	$ 1,919,411		$ 167,901	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle National Bank		X	Mortgage	$ 2,206 + int	08/31/02	$ 2,036,866	$ 1,972,688	08/31/07	Variable	$ 105,452	1
2	Bank of Farmington		X	Purchase of Van	$761.65	08/10/99	45,000	0	08/10/04	0.0775	1,292	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle National Bank		X	Line of credit	interest only	08/31/03	176,718	0	08/31/04	Variable	5,477	6
7												7
8												8
9	TOTAL Facility Related				$761.65		$ 2,258,584	$ 1,972,688			$ 112,221	9
	B. Non-Facility Related*											
10												10
11								Home Office Allocation			5,332	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 5,332	14
15	TOTALS (line 9+line14)						$ 2,258,584	$ 1,972,688			$ 117,553	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 9,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 10,522	2
3. Under or (over) accrual (line 2 minus line 1).		$ 922	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,523	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Allocation from home office TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ 346	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 11,791	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	8,581	8
	2000	8,886	9
	2001	9,338	10
	2002	9,508	11
	2003	10,522	12

Real estate tax accrual based on 100% of the prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor Nursing Home COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0026716

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-001-047-00	Lot 12, Albro Palmers etal sub div	$ 4,432.00	$ 4,432.00
2.	21-001-048-00	N Pt Lot 13, Albro Palmers etal sub d	$ 5,561.00	$ 5,561.00
3.	21-001-049-00	40 Center Lot 13, Albro Palmers Etal	$ 529.00	$ 529.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 10,522.00	$ 10,522.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	42,108	1977	$ 25,000	1
2	Resident Care	18,797	2003	159,891	2
3	TOTALS	60,905		$ 184,891	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1977	1977	$ 340,200	$	25	$	$	$ 340,200	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	357		20			357	9
10	Various			1979	62,800		25			62,800	10
11	Various			1983	27,383					27,383	11
12	Various			1984	3,788		20			3,788	12
13	Various			1985	4,563	151	20		(151)	4,563	13
14	Various			1989	6,368	202	20	318	116	5,915	14
15	Various			1991	5,525	175	20	276	101	4,249	15
16	Various			1992	14,285	458	20	714	256	9,056	16
17	Various			1995	18,999	429	20	950	521	8,705	17
18											18
19	Tile flooring			1996	991	25	20	50	25	450	19
20	Curtains			1996	3,187		20	159	159	1,365	20
21	Mini blinds			1996	358		20	18	18	155	21
22	Concrete parking lot			1996	1,250	74	20	63	(11)	530	22
23	Paving and lining parking lot			1996	8,325	494	20	416	(78)	3,363	23
24											24
25	Electrical box			1997	3,777	97	20	189	92	1,512	25
26	Medicare survey			1997	1,543		20	77	77	578	26
27	Windows			1997	1,640	42	20	82	40	615	27
28	Screen patio			1997	8,369	215	20	418	203	3,065	28
29	Seal coat parking lot			1997	675	30	20	34	4	247	29
30											30
31	Landscaping			1998	4,553	280	15	304	24	1,871	31
32	Remodeling			1998	1,822	47	20	91	44	592	32
33	Siding & windows			1998	39,885	1,023	20	1,994	971	12,961	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Outdoor sign	1999	$ 1,036	$ 92	20	$ 52	$ (40)	$ 312	37
38	Sprinkler heads	1999	2,187	56	20	109	53	654	38
39	Handicapped bathrooms	1999	23,785	628	20	973	345	5,838	39
40	Nurse call system	1999	3,648	94	20	182	88	1,092	40
41									41
42	Roof	1999	21,735	557	20	1,087	530	6,522	42
43	Fencing	1999	2,777	173	20	139	(34)	834	43
44	Windows	1999	1,250	32	20	63	31	378	44
45									45
46	Garage & patio	1999	15,560	399	20	778	379	4,668	46
47									47
48	Windows	2000	1,233	32	20	62	30	279	48
49	Key system	2000	1,080	34	20	54	20	243	49
50	Resurface parking lot	2000	1,950	140	20	98	(42)	441	50
51									51
52	Kitchen remodeling	2001	2,152	55	20	108	53	378	52
53	Air compressor	2001	5,900	151	20	295	144	1,033	53
54	Carpet	2001	1,221	31	20	61	30	214	54
55	New roof - shed	2001	1,320	34	20	66	32	231	55
56	Remodel skilled units	2001	5,897	151	20	295	144	1,032	56
57									57
58	Building upgrades	2002	4,937	127	20	247	120	617	58
59	Nurses station cabinets	2002	2,369	414	20	118	(296)	295	59
60									60
61	Gutters and drains	2003	3,400	416	20	170	(246)	255	61
62	Hot water heater	2003	1,932	237	20	97	(140)	145	62
63									63
64	Boiler/Hot Water	2004	1,525	218	20	38	(180)	38	64
65	ADT Smoke detecor	2004	6,176	882	20	154	(728)	154	65
66	Fire Suppression System	2004	1,920		20	48	48	48	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 675,633	$ 8,695		$ 11,447	$ 2,752	$ 520,021	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 166,675	$ 12,929	$ 16,668	$ 3,739	10	$ 74,915	71
72	Current Year Purchases	6,433	1,004	322	(682)	10	322	72
73	Fully Depreciated Assets	98,890					98,890	73
74	Home office allocation			4,666	4,666			74
75	TOTALS	$ 271,998	$ 13,933	$ 21,655	$ 7,722		$ 174,127	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	89 Ford Van	1993	$ 10,795	$	$	$	5	$ 10,795	76
77	Facility	Hossler Van	1999	40,785				5	40,785	77
78										78
79										79
80	TOTALS			$ 51,580	$	$	$		$ 51,580	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,184,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,628	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,103	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,475	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 745,728	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Additional Resident Rooms	$ 151,614	92
93			93
94			94
95		$ 151,614	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5			Home office allocation		2,702			5
6								6
7	TOTAL				$ 2,702 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,993 Description: Dish Machine $640, Air Mattress $870, Wound Care Vacuum$1,389, Home Office Allocation $94
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$		$ 36,112	$		$ 36,112	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs			30,234			30,234	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs			59,102			59,102	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				11,371		11,371	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A						6,246		6,246	13
14	TOTAL			$		$ 125,448	$ 17,617		$ 143,065	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider #: 0026716
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Outside Practioner Cost	Supplies
Oxygen	L39, C2			775
Excel Meds	L39, C2			5,471
Total			0	6,246

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,755,560	$ 1,755,560	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	239,072	239,072	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,280	2,280	7
8	Accounts Receivable (owners or related parties)	1,063,568	1,063,568	8
9	Other(specify): Due from medicaid Residents	14,738	14,738	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,075,218	$ 3,075,218	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	203,695	184,891	13
14	Buildings, at Historical Cost	672,536	675,633	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	338,877	323,578	16
17	Accumulated Depreciation (book methods)	(819,389)	(745,728)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in Progr	151,614	151,614	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 547,333	$ 589,988	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,622,551	$ 3,665,206	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,304,393	$ 1,304,393	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,222	72,222	30
31	Accrued Taxes Payable (excluding real estate taxes)	242	242	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,523	10,523	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	7,965	7,965	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,395,345	$ 1,395,345	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,972,688	1,972,688	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,972,688	$ 1,972,688	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,368,033	$ 3,368,033	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 254,518	$ 297,173	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,622,551	$ 3,665,206	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 105,576	1
2	Restatements (describe):		2
3	**Prior period adjustments**	25,453	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 131,029	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	123,489	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 123,489	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 254,518	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,866,558	1
2	Discounts and Allowances for all Levels	1,425	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,867,983	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,235	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,235	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,420	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,966	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,210	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 10,596	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	426	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 426	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,128,243	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	406,082	31
32	Health Care	890,699	32
33	General Administration	491,991	33
	B. Capital Expense		
34	Ownership	150,930	34
	C. Ancillary Expense		
35	Special Cost Centers	27,720	35
36	Provider Participation Fee	37,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,004,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	123,489	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 123,489	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 42,689	$ 20.52	1
2	Assistant Director of Nursing	2,150	2,150	33,053	15.37	2
3	Registered Nurses	4,507	4,779	85,345	17.86	3
4	Licensed Practical Nurses	9,846	10,102	152,547	15.10	4
5	Nurse Aides & Orderlies	35,658	37,183	320,366	8.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,218	1,368	15,666	11.45	8
9	Activity Director	2,080	2,080	17,253	8.29	9
10	Activity Assistants					10
11	Social Service Workers	3,733	3,733	35,118	9.41	11
12	Dietician					12
13	Food Service Supervisor	1,820	1,820	16,277	8.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,241	10,305	57,106	5.54	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	19,413	9.33	17
18	Housekeepers	10,626	11,110	68,920	6.20	18
19	Laundry	3,780	3,818	22,548	5.91	19
20	Administrator	2,080	2,080	60,674	29.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,899	94,688	$ 946,975 *	$ 10.00	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	8,019	L09, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	525	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 8,544		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susie Shaw	Administrator	0	$ 60,674
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,674

B. Administrative - Other

Description	Amount
Management fees - eliminated in column 7	$ 184,821
TOTAL (agree to Schedule V, line 17, col. 3)	$ 184,821
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder Associates	Legal	$ 446
Ginoli & Company	Accounting	6,000
Altschuler Melvoin & Glasser	Accounting	5,575
Mary Albert - Fitz	Accounting	280
ADP	Computer	7,088
AOL	Computer	300
IVANS	Computer	553
Administar	Computer	119
Arch Wireless	Computer	57
LTC Solutions	Computer	1,320
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,873
Unemployment Compensation Insurance	14,550
FICA Taxes	70,838
Employee Health Insurance	34,107
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
401 (k) retirement plan	1,912
Employee morale	3,936
TOTAL (agree to Schedule V, line 22, col.8)	$ 155,216

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	474
Health Care Worker Background Check	
(Indicate # of checks performed 20)	251
Miscellaneous dues	106
IEPA Sewer Permit	800
Home office allocation	515
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	370
Seminar Expense	
Home office allocation	1,401
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,771

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider #: 0026716
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	21,738
Allocated from Management Company	
Legal	1,892
Other	9,677
Total (agree to Schedule V, line 19, column 8)	33,307

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **132** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **37,332**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,420**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	73,383	9,677	0	83,060	0	83,060	5,470	88,530
2. Food Purchase	0	98,332	0	98,332	0	98,332	-3,418	94,914
3. Housekeeping	68,920	8,236	0	77,156	0	77,156	22	77,178
4. Laundry	22,548	6,326	0	28,874	0	28,874	-801	28,073
5. Heat and Other Utilities	0	0	65,200	65,200	0	65,200	474	65,674
6. Maintenance	19,413	33,201	846	53,460	0	53,460	1,341	54,801
7. Other (specify)*	0	0	0	0	0	0	934	934
8. Total General Services	184,264	155,772	66,046	406,082	0	406,082	4,022	410,104
9. Medical Director	0	0	8,019	8,019	0	8,019	0	8,019
10. Nursing & Medical Records	649,666	50,533	525	700,724	0	700,724	11,467	712,191
10a. Therapy	0	0	125,448	125,448	0	125,448	4	125,452
11. Activities	17,253	3,446	0	20,699	0	20,699	5	20,704
12. Social Services	35,118	691	0	35,809	0	35,809	0	35,809
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	1,108	1,108
16. Total Health Care & Programs	702,037	54,670	133,992	890,699	0	890,699	12,584	903,283
17. Administrative	60,674	0	184,821	245,495	0	245,495	-120,774	124,721
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	21,738	21,738	0	21,738	11,569	33,307
20. Fees, Subscriptions & Promotion	0	0	3,621	3,621	0	3,621	515	4,136
21. Clerical & General Office	0	3,537	10,821	14,358	0	14,358	39,574	53,932
22. Employee Benefits & Payroll	0	0	155,216	155,216	0	155,216	0	155,216
23. Inservice Training & Education	0	0	769	769	0	769	660	1,429
24. Travel and Seminar	0	0	370	370	0	370	1,401	1,771
25. Other Admin. Staff Trans	0	0	4,114	4,114	0	4,114	2,693	6,807
26. Insurance-Prop.Liab.Malpractice	0	0	46,310	46,310	0	46,310	942	47,252
27. Other (specify)*	0	0	0	0	0	0	10,864	10,864
28. Total General Adminis	60,674	3,537	427,780	491,991	0	491,991	-52,556	439,435
29. Total General Administrative	946,975	213,979	627,818	1,788,772	0	1,788,772	-35,950	1,752,822
30. Depreciation	0	0	24,912	24,912	0	24,912	8,191	33,103
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	112,224	112,224	0	112,224	5,329	117,553
33. Real Estate	0	0	11,445	11,445	0	11,445	346	11,791
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,702	2,702
35. Rent - Equipment & Vehicles	0	0	2,349	2,349	0	2,349	644	2,993
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	150,930	150,930	0	150,930	17,212	168,142
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	17,617	0	17,617	0	17,617	0	17,617
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	37,332	37,332	0	37,332	0	37,332
43. Other (specify):*	0	0	10,103	10,103	0	10,103	-10,103	0
44. Total Special Cost Ce	0	17,617	47,435	65,052	0	65,052	-10,103	54,949
45. Grand Total	946,975	231,596	826,183	2,004,754	0	2,004,754	-28,841	1,975,913

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,755,560	1,755,560
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	239,072	239,072
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	2,280	2,280
8. Accounts Receivable-Owner/Related Party	1,063,568	1,063,568
9. Other (specify):	14,738	14,738
10. Total current assets	3,075,218	3,075,218
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	203,695	184,891
14. Buildings, at Historical Cost	672,536	675,633
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	338,877	323,578
17. Accumulated Depreciation (book methods)	-819,389	-745,728
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	151,614	151,614
23. other (specify):	0	0
24. Total Long-Term Assets	547,333	589,988
25. Total Assets	3,622,551	3,665,206
CURRENT LIABILITIES		
26. Accounts Payable	1,304,393	1,304,393
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	72,222	72,222
31. Accrued Taxes Payable	242	242
32. Accrued Real Estate Taxes	10,523	10,523
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	7,965	7,965
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,395,345	1,395,345
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,972,688	1,972,688
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,972,688	1,972,688
46.Total Liabilities	3,368,033	3,368,033
47.Total Equity	254,518	297,173
48.Total Liabilities and Equity	3,622,551	3,665,206

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,866,558
2. Discounts and Allowances for all Levels	1,425
Subtotal - Inpatient Care	1,867,983
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	249,235
7. Oxygen	0
Subtotal - Anciliary Revenue	249,235
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,420
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	1,966
20. Radiologyand X-Ray	0
21. Other Medical Services	5,210
22. Laundry	0
Subtotal - Other Operating Revenue	10,596
24. Contributions	0
25. Interest and Other Investments Income	3
Subtotal - Non-Operating Revenue	3
27. Other Revenue (specify):	426
28. Other Revenue (specify):	0
Subtotal - Other Revenue	426
30. Total Revenue	2,128,243
31. General Services	406,082
32. Health Care	890,699
33. General Administration	491,991
34. Ownership	150,930
35. Special Cost Centers	27,720
35. Provider Participation Fee	37,332
37. Other	0
40. Total Expenses	2,004,754
41. Income Before Income Taxes	123,489
42. Income Taxes	0
43. Net Income or Loss for the Year	123,489

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